DECLARATION OF OLIVIA J. FLECHSIG

I, Olivia J. Flechsig, declare as follows:

1. I am an attorney licensed to practice law in California. I am an associate with the law firm Allred, Maroko & Goldberg, counsel of record for Plaintiff Mark Snookal. I have personal knowledge of the facts set forth below and, if called as a witness, could and would testify competently to such facts under oath.

2. I took the deposition of Scott Levy, M.D. on August 30, 2024, and I am in possession of a certified copy of his deposition transcript. Attached hereto as **Exhibit 12** is a true and correct copy of relevant excerpts from Dr. Levy's deposition transcript. During his deposition, Dr. Levy authenticated a number of documents including those that were marked as Exhibits C and E, which are each referenced in the concurrently filed Joint Brief re Motion for Summary Judgment and Statement of Uncontroverted Facts and Genuine Disputes. Those documents are attached hereto as **Exhibits 12-C and 12-E:**

Exhibit 12-C: August 23, 2019 E-mail from Dr. Khan to Dr. Levy

Exhibit 12-E: Expatriate Assignment History & Physical Examination Form for REM Position

3. I took the deposition of Dr. Ujomoti Akintunde on October 31, 2024, and I am in possession of a certified copy of his deposition transcript. Attached hereto as **Exhibit 13** is a true and correct copy of relevant excerpts from Dr. Akintunde's deposition transcript.

4. I took the deposition of Dr. Victor Adeyeye on November 15, 2024, and I am in possession of a certified copy of his deposition transcript. Attached hereto as **Exhibit 14** is a true and correct copy of relevant excerpts from Dr. Adeyeye's deposition transcript.

5. I defended the deposition of Shahid Hameed Khan, M.D. on February 10, 2025, and I am in possession of a certified copy of his deposition transcript.

Attached hereto as **Exhibit 15** is a true and correct copy of relevant excerpts from Dr. Khan's deposition transcript.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this Declaration was executed on March 20, 2025, at Los Angeles, California.

Olivia J. Flechsig

EXHIBIT 12

UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

_____

MARK SNOOKAL, an individual, Plaintiff, vs. CHEVRON USA, INC., a California Corporation, and DOES 1 through 10, inclusive, Defendants.	)	Case No. 2:23-cv-6302-HDV-AJR

REPORTER'S TRANSCRIPT

VIDEOTAPED DEPOSITION OF

SCOTT LEVY, M.D.

Friday, August 30, 2024

Via Zoom Video Conferencing

9:31 a.m.

Reported by: Rachel N. Barkume, CSR, RMR, CRR
Certificate No. 13657

EXHIBIT 12-1

A P P E A R A N C E S

FOR THE PLAINTIFF:

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THE VIDEOGRAPHER:

Jacob Rivera

Q. Anyone other than your attorney?
A. I have not.
Q. Okay. Have you ever been convicted of a crime?
A. I have not.
MR. MUSSIG: Okay.
THE WITNESS: Oh, sorry.
MR. MUSSIG: I would object on privacy grounds, but you've already answered, so...
BY MS. FLECHSIG:
Q. Okay. And what's your date of birth, Dr. Levy?
A. April 8, 1973.
Q. Okay. So you're currently an employee of Chevron; correct?
A. I am.
Q. Do you know what the name of the entity you work for is, like, specifically, like, the corporate entity, to clarify?
A. I work for -- it changes all the time, which makes things a little complicated, but I work for Chevron USA.
Q. Okay. Do you know when that last changed?
A. No, it's not clear. And I can explain. I've had several assignments with the company throughout my 12 years here, and so I've worked under different businesses, so it's -- but I think I've -- I think

technically I may have always been on the Chevron USA. I'm just not completely aware. I've never changed payrolls or anything like that, though.

Q. Okay. Is your understanding that your paychecks are paid by Chevron USA or Chevron USA Inc.?

A. It is my understanding that that's what happens, yes.

Q. Okay. I think you just said you worked for Chevron for 12 years, so you would have started in or about 2012?

A. Correct.

Q. Okay. I want to go through just your whole, sort of, work history with Chevron.

What -- what was your role when you started in 2012?

A. I started as -- my title was the occupational health manager for North America.

Q. What -- just, sort of, briefly, what kind of job were you doing in that capacity?

A. Sure. So my -- my agreement was our businesses across -- like, across North America -- my job was to -- I was an internal consultant to our businesses.

So if our businesses needed to set up medical operations, I would be the one to help with that and advise. I would also help run their occupational health

program across North America and then involved with different health and wellness events as they arose.

(Reporter clarification.)

BY MS. FLECHSIG:

Q. How long were you in that occupational health role?

A. It was about two years or so.

Q. What was your next role?

A. I was moved to Singapore, and I was assigned the role of regional medical manager for the Asia Pacific region.

Q. What did you do in that capacity?

A. Similar responsibilities just -- I guess, more of a -- of a senior position. So I managed, again, more complicated businesses and had more reports.

Q. How long were you in that role?

A. Three years approximately.

Q. Okay. And after that -- excuse me, the role in Singapore, what was your next role at Chevron?

A. I took a lateral position to regional medical manager of our EEMEA, E-E-M-E-A, region, which is Europe, Eurasia, Mid East, and Africa, based out of London.

Q. Okay. So what was the date range on that -- on that role? I want to -- like, in time.

A. It ended on May 31st of this year. So I moved to my current role May 31 -- on June 1st. So it was May 31st and then I would subtract seven years. 2017 roughly, '18.

Q. Started 2018, and then you were in that role until May 31st, 2024?

A. Correct.

Q. Okay. Were you located in London that whole time?

A. I was.

Q. Okay. And what's your current role?

A. I now have the role of regional medical manager for the Americas based out of Houston.

Q. Do you know what entity -- what Chevron corporate entity was your employer during the time you were the regional medical director for the EEMEA role?

A. Yeah, so I was working out of the -- it was Chevron Products UK. And, again, that was the title that we used in my signature. I can't tell you the technical bits, though, about payroll and whether I was paid through Chevron USA or not, but my paychecks remain the same -- through the same -- for my 12 years that I was a Chevron employee.

Q. You mean the entity that's paying your paycheck is the same?

A. I kept the same benefits. I kept the same -- nothing's really changed. I stayed on the same payroll. Obviously the amounts changed, but -- over time, but no, it's the same payroll. That's more of an HR question. I don't have the -- the info, I guess. I don't know the answer.

Q. And prior to starting work with Chevron, where were you employed?

A. I worked for the Permanente Medical Group. It's a large physician group in Northern California.

Q. Is that -- I'm sorry, you said Permanente?

A. The Permanente -- "permanent" with an E. Permanente Medical Group.

Q. Okay.

A. TPMG.

Q. Okay. So did you practice medicine, then, between the time -- like, up until the time you joined Chevron?

A. I did.

Q. Okay. And when did you graduate from medical school?

A. '99.

Q. And then you completed residency?

A. I completed two residencies, yes.

Q. Okay. What were your residencies?

Q. Okay. Do you -- did you get any specialized training in cardiology?

A. I have not.

Q. Do you have any Board certifications?

A. I'm Board-certified in internal medicine and occupational environmental medicine as well.

Q. Okay. So I want to ask about your job duties while you were the regional medical director of the EMEA region -- am I getting the acronym correct?

A. You are, yes.

Q. EMEA. Okay.

While you were the regional director of the EMEA region, what were your job duties?

A. Yeah, it's EEMEA. But that's okay.

Q. EEMEA.

A. Yeah. That's okay.

Q. Thank you.

A. My job duties -- so again, internal consultant to our businesses, we've had -- again, a lot of our -- we have new business, we have old business, we have small projects, big projects. So I would say that for the large projects, they had embedded medical teams. So my job was usually to interact with the teams, make sure that they got what they needed. I would help them -- I would help train or mentor. I would review processes

and try to align some of the work coming from our corporate function down to the embedded businesses.

I would also serve as -- I would manage emergencies. So when I say "emergencies," the -- if there wasn't anyone present, we didn't have a medical operation on the ground in a certain country, I would help facilitate care for our people to get them where they needed to be.

So lots of medical evacuations and things like this. A lot of cross-border transfers. So let's just say -- we're talking about a case from Nigeria today. So if I was -- so if we were evacuating someone from Nigeria, I would help facilitate care from Nigeria out to another country, manage the issue -- or help case manage the issue while in that second country, and then see the process to the end when we get the person back home safe and sound.

And so those would be some of the things we do. I -- we would help put together health-and-wellness-related programs and things like that to keep employees safe, to keep -- to keep the workforce healthy, and then we would also review and evaluate our fitness-for-duty programs to make sure that they were functioning as intended.

Q. Okay. So in terms of managing the

fitness-for-duty programs, do you get to create the policies and protocols for how the evaluations are carried out?

A. Influence. I influence it, yes.

Q. Okay. What do you mean you "influence it"?

A. So we have policies related to fitness for duty, and I'm jumping -- maybe jumping ahead because this is an expat-related case, and so -- so in this situation, we -- there's a policy for expat medical clearances.

And as time goes and things need to be updated, I may pass on my thoughts and ideas to the -- to the team that manages the policies.

Q. Okay. What team manages the policies?

A. So at the time, the team was called the Center of Excellence.

Q. Okay. And that's a -- Chevron corporate or --

A. Sorry. Yes. I'm sorry for speaking over you.

Yes, that is -- it's a function under our health and medical department.

Q. So what kind of -- I guess what kind of consulting role do you have on creating the policies and practices for that, then?

A. So --

MR. MUSSIG: Vague as to time.

BY MS. FLECHSIG:

Q. Yeah. I can clarify.

I do mean, you know, while you were the regional EEMEA director.

A. Sure. So the countries change over time. Sometimes the countries get safer, sometimes they get less safe, sometimes they have issues. And so mostly it was taking a look at frequency of the evaluations, taking a look at the new risks that may be in a location that weren't there before.

Again, things could be -- infectious diseases that are in a place, cholera, malaria, ebola at times -- so making sure that when we send people from one location to another that the -- that, A, they're safe to be there; and, B, they're -- we can keep them safe from whatever outside hazards they would -- they may -- they may face, and they're well-informed of their risks.

Q. Okay. So -- so in other words, you have a role in evaluating the real-time risks based on location.

A. Correct.

Q. Okay. And you then give recommendations for policy setting for the fitness-for-duty program to the --

A. Correct.

(Reporter clarification.)

MS. FLECHSIG: Center for Excellence.

THE WITNESS: Center of Excellence.

MS. FLECHSIG: Center of Excellence. Excuse me. Okay.

BY MS. FLECHSIG:

Q. In terms of -- you also mentioned one of your duties is to manage emergency medical evacuations --

A. Correct.

Q. -- and oversee care, you know, when someone has been evacuated.

A. Correct.

Q. What -- I guess, what do you -- strike that.

Do you also get to create policies and protocols for medical evacuations?

A. Correct.

Q. Okay. And -- okay.

And you also would, you know, carry them out in real time when something happens.

A. Yes.

Q. Okay. And at the time you were the regional director for the EEMEA region, you would have been personally responsible for overseeing any medical evacuations from within your region?

A. I would be responsible for -- it's a difficult question to answer, and I'll explain why. We had

approximately 300 medical evacuations a year in our region. Generally, the evacuations that would reach my level would be extremely complicated, not simple, and so I would not be involved in -- in every single evacuation.

I would be involved with anything that was very complex, that required international borders, critical patients, and -- or -- or maybe Q and A on an evacuation that had some issues done by our embedded medical teams.

(Reporter clarification.)

THE REPORTER: Just keep your voice up at the end. It kind of trails off on me.

THE WITNESS: Oh, sorry. Sorry.

THE REPORTER: Thank you.

BY MS. FLECHSIG:

Q. The embedded medical teams, just to clarify, those are the local medical teams on the ground.

A. Correct. And -- and in -- my medical teams for EEMEA, all of those medical teams reported to the businesses. They didn't report to me directly.

Q. Did you -- did you oversee the people who were handling less complicated medical evacuation?

A. When they were --

MR. MUSSIG: Vague as to "oversee." Go ahead. You can answer.

what I think the -- the risk may be or not be.

Q. So how did you -- how did you first become involved with Mr. Snookal's challenge to the host team deeming him unfit for duty?

A. I was asked as a second opinion to review the case.

Q. To provide a medical opinion on whether it was safe for him?

A. I was -- so I don't recall exactly, but I know Mr. Snookal asked for a second opinion and -- that, I know for a fact. And then this was sent to me for a review.

Q. Who sent it to you for review?

A. I don't remember. Again, it was years ago. I know Mark and I did speak, so I'm not sure if he approached me first or if someone sent it to me, but I do know that Mark and I chatted about his situation.

Q. Okay. So when you were asked to give a second opinion, were you allowed to override the decision that the host team had made?

A. I was not allowed to override, but I would say that the -- even the -- as I'm thinking of the word "second opinion," that might be incorrect as well. I would say that -- I was here to help with an appeal. So I would look at a case and see if there was anything

that was missed or some other information that might be pertinent to the case and then have that discussion, doctor to doctor, with our host medical team so they're aware of potentially mitigating factors.

So it wasn't necessarily a second -- a second opinion. It just -- maybe another opinion or -- maybe that's not necessarily different. But just assist with an appeal. But -- but the absolute -- the final decision was with the host location.

Q. Okay. At the time that you were the regional medical director for the EEMEA region, do you recall anyone else who complained about the host decision not to allow the transfer to take place?

A. No.

Q. Okay. So Mark Snookal was the only time -- Mark Snookal's complaint about the decision was the only time you became involved in that way --

A. Correct.

Q. -- to give a second opinion?

A. Correct.

Q. Okay. In terms of the organizational chart, are you considered the supervisor of the host medical teams?

A. I am not.

Q. Okay. Who would be supervising those folks?

MR. MUSSIG: Calls for speculation. Lacks foundation.

THE WITNESS: In this specific business, H -- the medical team reported to HR.

BY MS. FLECHSIG:

Q. Okay. So you said "this specific business."

Are you referring to the Escravos, Nigeria, location -- host location? Okay.

A. I'm -- I'm referring to the medical team that made the decision in Nigeria.

Q. Okay. Who made the decision in Mr. Snookal's instance; right?

A. Yeah, it was Dr. Asekomeh -- don't ask me to spell that at this moment, but -- you may have it already.

Q. Is it Dr. -- and I may well be butchering this as well -- Dr. Asekomeh?

A. That sounds correct.

Q. Okay. So --

MR. MUSSIG: That is, by the way, the correct pronunciation. It took me a while.

MS. FLECHSIG: Thank you. I came up with that myself. I -- okay. Great.

MR. MUSSIG: Oh, wait, no, it's Asekomeh.

MS. FLECHSIG: Asekomeh.

MR. MUSSIG: Asekomeh.

MS. FLECHSIG: Okay.

BY MS. FLECHSIG:

Q. So your understanding is Dr. Asekomeh reported to Chevron human resources.

A. No. He reported to the medical director for Nigeria. Sorry.

MR. MUSSIG: Calls for speculation. Lacks foundation.

BY MS. FLECHSIG:

Q. Sorry. Go ahead. You -- you said he reports to the medical director in Nigeria.

A. Correct.

Q. Okay. And then I think you said somebody reports to HR.

Who then reports up into Chevron's human resources?

A. The medical director.

MR. MUSSIG: Calls for speculation. Lacks foundation.

THE WITNESS: The medical director then reports to HR.

BY MS. FLECHSIG:

Q. Who was the medical director in Nigeria?

A. It was at this -- at the time of this case, it

was Dr. Arenyeka, A-R-E-N-Y-E-K-A.

Q. Okay. And is that -- if you know, is the human resources department that Dr. Arenyeka reports to -- is that Chevron USA, or what -- do you know what the corporate entity is?

A. So --

MR. MUSSIG: Calls for speculation.

THE WITNESS: We call the business NMA, so it's the North African -- North -- it's -- NMA is the abbreviation. I'm -- North -- Nigeria Mid Africa business unit.

BY MS. FLECHSIG:

Q. Okay. Do you know what medical specialty Dr. Arenyeka has?

A. I don't recall.

Q. Okay. Okay. So when you became involved in giving a second opinion on Mr. Snookal's challenge to the host location's determination, what did you do to inform your second opinion?

MR. MUSSIG: Misstates the witness's testimony.

THE WITNESS: So I'm not sure I understand the question. Could you please repeat it?

BY MS. FLECHSIG:

Q. Yeah. So you said you were asked by somebody to give a second opinion on Mr. Snookal's fitness for

duty in -- for the expatriate assignment; right?

MR. MUSSIG: Misstates the witness's testimony.

THE WITNESS: Correct. Correct. Yeah. I -- again, I don't remember how -- how I was contacted initially, but I was obviously dragged into discussion or at least into the case one way or another, but -- so I had a conversation with Mr. Snookal as a first line to understand what was going on.

I received his impression of the situation, discussed the issues with him, discussed some of the details of his medical condition, and then asked permission to speak with his medical -- his treating medical provider.

BY MS. FLECHSIG:

Q. Okay. In terms of his treating medical provider, was that his treating cardiologist?

A. Correct.

Q. And did you -- did you speak with Dr. Khan, the cardiologist?

A. I spoke with Dr. Cardio- -- Dr. Khan via messaging. So I left a voicemail for him explaining who I was and what I was trying to do, and then he responded in an e-mail.

Q. Did you ever speak in real time over the phone

or in person?

A. I don't recall. I -- I don't recall.

Q. Okay. You don't recall whether you did, or you don't recall speaking with him?

A. I don't recall speaking with him on the phone.

Q. Okay. And in your recollection, what did Dr. Khan say to you about his evaluation of Mr. Snookal's health?

A. The -- I'll get to the summary. So what he explained to me and -- was that he has this condition; he's been followed; and for the last three years, they haven't seen a significant or any increase in the size of his problem. And he gave me some risk -- what the -- what his risk of -- of a subsequent event was.

So I believe the message that I left for him was that I'm trying to understand the risk. The data that I pull up shows he's got about a 4 or 5 percent risk of a cardiac event per year -- you know, currently, and I just need to better understand to -- to be able to fine tune or decide if that number is -- has any validity at all.

And so he responded with he believes that the individual's risk of having a cardiac event -- or an event related to his condition was about 2 percent a year. He quoted some studies in mice, and he said that

those were positive, and potentially his -- his risk could be less than 2 percent a year.

Q. Okay. In terms of the -- you said that according to your data, there was a 4 to 5 percent risk of a cardiac event per year.

A. Yes.

Q. How did you get that figure?

MS. FLECHSIG: Sorry, Dr. Levy --

MR. MUSSIG: Is he frozen?

MS. FLECHSIG: I think it's just him. He froze.

MR. MUSSIG: Okay.

MS. FLECHSIG: Dr. Levy, are you there?

MR. MUSSIG: He's still frozen for me.

MS. FLECHSIG: Yeah. Me too.

THE VIDEOGRAPHER: Would you like to go off the record?

MR. MUSSIG: Yeah, maybe -- yeah, we've been going about an hour. Does it make sense to take a break now?

MS. FLECHSIG: I mean, I'd rather not, you know, break while we're -- have a question pending, but -- Dr. Levy, are you there? I see you turned your video off.

MR. LEAL: Does it make sense to ask him to log

THE WITNESS: Oh, no, we're good. We're good now. I can see this. And this is easier for me at the moment.

BY MS. FLECHSIG:

Q. Okay. So I'm going through -- it looks like it's an e-mail from Mr. Snookal to you on August 23rd, 2019; correct?

A. Correct.

Q. Okay. So I see the screenshot Mr. Snookal included in his e-mail to you, which has a chart of maximal aortic diameter and probability of aortic events in one year.

A. Uh-huh.

Q. When you were evaluating the risk of an adverse event for Mr. Snookal, did you consider the actual diameter of his aortic aneurysm?

A. Absolutely. That's -- the larger the diameter is, the higher the risk is. Very similar to this chart. The numbers we can debate, but, yeah, it's absolutely relevant.

Q. Okay. Did you also consider the changes or lack of changes in the diameter over time and whether that impacted Mr. Snookal's risk?

A. I have. Yes, I did.

Q. Okay. Did you evaluate whether Mr. Snookal's

management with medication impacted the risk of an adverse outcome due to the aortic aneurysm?

A. So the fact that he was on his medications and the aneurysm had not grown in those three years -- I took that as he was relatively stable.

Q. So, yes, you did consider it.

A. Correct. Correct. Yes. Considered it, yes.

Q. Okay. And this e-mail, it does say that Mr. Snookal attached a past research and he found a paper.

Did you look at --

A. I think --

Q. -- the attachment that he included?

A. No. So I believe that the attachment that he included is that photo right below.

Q. Okay. So your sense is that there was not any separate attachment to this e-mail.

A. Correct.

Q. Okay.

A. I actually believe there was a -- there was an attachment to the e-mail, but it was the article that I sent to him. So he just replied with attachments and then added this to the -- to the e-mail message.

Q. Okay. Let's see if we can track down the article. I'm going to screen share this with you as

A. Yes.
Q. -- about Mr. Snookal's risk?
A. I would have, yes, correct. I would have.
Q. Okay. Okay. Did you review any of Mr. Snookal's actual medical records in formulating your opinion?
A. I did not. I -- I reviewed the medical evaluations that he had for Chevron, and I reviewed his message -- or letter from his cardiologist. So the -- the key bit here is -- it's a risk tolerance issue.
So he has a medical issue with a risk, and we can debate the risk even on this call, but there's a certain risk and the -- the determination was based on the host location's willingness to accept that risk.
MR. MUSSIG: Do you -- he -- oh, it's me.
BY MS. FLECHSIG:
Q. Okay.
MR. MUSSIG: Can you guys hear me?
MS. FLECHSIG: Yes.
MR. MUSSIG: My computer froze for a second.
MS. FLECHSIG: Yeah.
BY MS. FLECHSIG:
Q. Okay. So ultimately, the host location gets to decide how much risk they're willing to tolerate at their site; correct?

A. Correct. It's -- yeah, it is -- that's exactly right. And then the risk is a combination of things; right? It's the -- it's -- we need to know what the condition is so we know what the risk is that we're taking. If it's -- if the risk is high risk that someone's going to sprain their ankle, not so relevant; but if it's -- you know, if it's a -- if it's a risk that someone's going to potentially die or have a very bad outcome, then it becomes very significant as far as the discussion goes.

Q. So when the host location makes a determination, I guess, what -- what role do you have in whether it's too much risk for Chevron to tolerate?

A. My job in this situation would be to better clarify the risk for them. And I believe in our situation -- I don't -- I don't believe that anyone had a conversation with the cardiologist.

I did get the specifics from the cardiologist about what his individualized risk is, again, not based on studies, not based on -- not based on studies that may or not -- may not pertain to him, but what his -- what his treating cardiologist thought the risk was for him. And I used this information to try to make a case for Mr. Snookal with the medical team.

Q. Did you have -- did you ever suggest that

Dr. Asekomeh speak with Dr. Khan?

A. No, I did not. I felt that I had enough information. Usually it's pretty complicated to make those connections work, given the time zones.

Q. Okay. So did you suggest that anyone from the host team speak with Dr. Khan?

A. I did not -- I did not have that conversation. Correct.

Q. Okay.

A. I did pass on the information word for word from Dr. Khan to the medical team, though.

Q. Did you speak with Dr. Asekomeh about Mr. Snookal's case?

A. I believe I forwarded him -- the information to Asekomeh and Arenyeka, his boss. And Arenyeka responded with the risk is -- the risk in this location is still too high and, if possible, we'd be very happy to take him in Lagos where we have medical resources. And I'm paraphrasing.

Q. Other than the e-mail exchange that you just described, did you speak with Dr. Asekomeh about Mr. Snookal in real time, like, over the phone or video --

A. I don't recall. I don't recall that.

(Reporter admonishment.)

BY MS. FLECHSIG:

Q. You don't recall speaking with him directly.

A. Correct. I don't recall speaking with him.

Q. Okay. Did you speak with Dr. Arenyeka about Mr. Snookal directly, other than the e-mail that you described?

A. Not about -- not about this case. I -- sorry, I don't recall speaking to him about this case.

Q. Okay. Did you speak with any other doctors in Nigeria about Mr. Snookal's case?

A. I have not.

Q. Okay. And that includes over e-mail. You didn't have any e-mail communications with anyone other than what you described with Dr. Asekomeh and Dr. Arenyeka.

A. Not to my knowledge, no.

Q. Okay. Okay. Other than the e-mail you described -- I know you paraphrased with Dr. Asekomeh and Arenyeka, did you have any other written exchanges with them about Mr. Snookal?

A. No, I don't believe so. It was a simple, this is the information from his provider, the risk doesn't appear high, it appears of low to moderate -- I believe I said risk doesn't appear high, and their response was simply the risk is still too high for us.

approach his cardiologist to talk about why he does -- why -- whether that pertains to him or not. So I would say that 4 or 5 is only my initial start at an appeal to try to acquire more information.

Q. Okay. I'm going to show you another document. I'll mark it as Exhibit C.

(Exhibit C marked for identification.)

BY MS. FLECHSIG:

Q. It's been produced as SNOOKAL-01091. And I think for this one, it's just a one-pager, so I'll screen share. And if you're having issues reading it, please let me know.

A. Yeah, if you could zoom in, please. Okay.

Q. So it looks like it's an August 23rd, 2019, e-mail from Dr. Steven Khan to you, scottlevy@chevron.com with a CC to Mark Snookal?

A. Correct. Yes. I know this e-mail.

Q. Okay. I'll give you a second to look at it.

Okay. So in this e-mail, Dr. Khan cites a 2002 study. Is that the study that you are referring to in terms of how you came up with the 4 to 5 percent figure?

A. Yes. Actually, can you zoom in a little bit more, please?

Q. Yes. Of course. So I'm referring to this --

A. Yes, yes.

Q. That's the study that you were referring to?

A. Correct. Yes.

Q. Okay. Okay. So in this e-mail, Dr. Khan also notes that the studies of risk of rupture are fairly old, 2002, and treatment has improved, as has our understanding of aortic aneurysms.

A. Yes.

Q. So did you compare this 2002 study to more recent research?

A. I did not. I took the word of the expert and his treating provider who knows him better than I can. And I accepted his number as a little bit lower. He says the risk of complications related to thoracic aneurysm is low and likely less than 2 percent, but he -- he says that it's 2 percent, and then the mouse studies are likely -- likely show that he's better than 2 percent.

So that's what I took: 2 percent or lower was his risk. I didn't take zero was the risk. I took 2 percent or lower.

Q. Okay. So basically that was your final thought on the percentage of the risk that you then conveyed to the host team?

A. I conveyed this exact message. I forwarded

way or another with certainty. And so I apologize.

Q. Okay. Slightly different question.

Are you aware of anyone who died in Escravos before being medically evacuated?

A. I'm aware of people in Nigeria who have died -- working for us in Nigeria that have died without -- without warning. So sudden onset, found slumped over, found dead, found not waking up in the morning. So we've had cases like that. The -- yeah.

Q. Do you know where in Nigeria those deaths occurred?

A. So I believe they happened all over Nigeria and all of our operations. But Escravos is a very small location, and I want to be very careful about telling you anything that's not correct here.

Q. Are you aware of anyone who's ever been injured because of a medical evacuation, whether that's the person being evacuated or a personnel who's carrying out the evacuation?

A. No, I'm not aware of anyone that was injured as a result of a medical evacuation in Nigeria at all. So the -- in general, the -- we consider Escravos to be one of the most remote locations in our company, and the medical evaluation to -- for someone to get to Escravos is -- is -- let's just say it has a higher criteria of

Q. Okay.

A. And then the -- obviously, the condition itself will warrant different types of planes based on -- based on the capabilities, whether it needs to be ICU capable, whether it can handle heart attacks, whether it's just a simple transport. All of these things come into play. And then also visas of the -- visas or passports of the individual. Obviously, if we're going to move an individual somewhere, can they get into the host country that we're about to send them to. And the same for the medical team. Can the medical team get into the host country. So there are a lot of factors to play -- that come into play.

Q. Okay. I do want to ask -- I want to ask a question specific to Mr. Snookal.

So was there anything about the actual job that Mr. Snookal would have been performing in Escravos that would increase the risk of an adverse outcome to him?

MR. MUSSIG: Calls for speculation.

THE WITNESS: So I believe that Mr. Snookal was -- his proposed job in Nigeria was an office-based job with just mild to light lifting activities. I don't think it's significant -- I don't think it's of -- sorry, let me start over.

I don't think that his condition would have

been an issue for his proposed role, had it not been for the location.

BY MS. FLECHSIG:

Q. Okay. And in terms of the specific scenarios you were concerned about, it -- again, it was the aortic dissection or an aortic aneurysm; correct?

MR. MUSSIG: Asked and answered.

THE WITNESS: Yes.

BY MS. FLECHSIG:

Q. Were you concerned at all that Mr. Snookal would pose a threat to other people's safety?

MR. MUSSIG: Calls for speculation. Lacks foundation.

THE WITNESS: Potentially. And I would say it all -- again, it's so -- these are so complicated. So if -- I'll give you an example. If he were to have an event while he was on location, he would have tied up the medical team for potentially days trying to sort out his issue, if he survived that long during the evacuation. If he were doing something that were deemed safety sensitive -- and I'm not sure he had responsibilities that were -- if he were climbing up a ladder or climbing upstairs and fell over -- potentially a lot of things could have happened, and so it's -- it's not so easy to say.

It all depends on specifically what he was doing on location. And again, I didn't have an issue with the job at all. I don't think any of us had an issue with the specific type of work he was doing. We didn't have an issue -- even when he was declined or turned down for this assignment, still working at the refinery in Richmond, California, was still -- wasn't something that we even considered stopping him from doing because of the risk.

It was simply because of that -- that -- if there -- if that -- if that sort of 2 percent occurred while -- while he was on location, it was something that the team could not manage.

BY MS. FLECHSIG:

Q. Okay. Did you document any concerns that you had about any risk to other people that you thought Mr. Snookal could have?

A. I did not.

Q. Okay. Was it something that you were concerned with at the time in assessing the risk that the host location would tolerate?

A. So I don't think it -- so I don't think it ended up to be relevant in this situation. So -- and the reason being was there was no -- even the risk of 2 percent to himself was enough for them to say -- was

enough for them to say no. So I would say it wasn't even -- the risk to others wasn't even -- let's just say they didn't even have time to come up and -- or, no, it wasn't discussed. Not -- it wasn't discussed for me.

I don't know the discussions that they had inside of the Nigeria Mid Africa business unit, but it wasn't a discussion that I had with the medical teams.

Q. Okay.

A. Or Dr. Khan.

Q. I want to ask -- I'm going to show you another document. I'm up to Exhibit D now.

(Exhibit D marked for identification.)

BY MS. FLECHSIG:

Q. This is -- this has been produced as SNOOKAL-01088 through 01089.

Again, please go ahead and take a look at this. It looks like it's an e-mail from you to Mr. Snookal on September 16th, 2019.

I'm going to see if I can --

A. Can you zoom in, please?

Q. Yeah. Is that -- is that better?

A. Better, yes.

Q. Do you recall writing this e-mail to Mr. Snookal?

A. Can you scroll up to the top of it? Let me just --

Q. Yes.

A. I do. I do.

Q. Absolutely.

A. I know this message, yes.

Q. Okay. So in this e-mail, you send a list of locations where it sounds like you would be okay with Mr. Snookal working as an expatriate on assignment by Chevron; right?

A. So, yes, that's -- so that's what I did say. I said those are the locations that will -- would probably be perfectly fine. And then for the other locations, it's one where we'd specifically need to talk with the local -- I -- it would take additional work to -- to clarify.

Q. Okay. And when you created the list of ones that you did not foresee issues with, how did you come up with those locations?

A. Oh, so we have -- well, those are higher-quality medical infrastructures. And so -- so between the -- where the work locations are and the medical resources around them are a better fit for -- for dealing with an emergency and things like that.

So the -- and I believe we ranked the locations

A. Correct.

MR. MUSSIG: Calls for speculation.

BY MS. FLECHSIG:

Q. In terms of the -- in terms of procedurally, that's how this works; right?

A. Yeah. From what I see here, it looks like he did a physical exam and took the history and then wrote notes, even restrictions, correct. So I would assume -- from reading this, I would assume that this was a -- he did an actual exam on him.

Q. Okay. So ultimately, on the fifth page of this document, SNOOKAL-00609, Dr. Sobel checks, "Fit for duty with restrictions."

You see what I'm referring to; right?

A. Yes.

Q. And the restrictions are, "No heavy lifting greater than 50 pounds, needs review of recommend letter from cardiologist to clear him." Right?

A. Uh-huh, correct.

Q. Okay. So did you review the letter that Mr. Snookal's cardiologist provided?

A. I need to see it again to remember. Sorry.

Q. So -- no problem. I -- I was going to segue us there anyway. So I'll mark as Exhibit E --

MS. FLECHSIG: Is that right?

THE REPORTER: F.

MS. FLECHSIG: Okay. Thank you. Exhibit F, SNOOKAL-01090.

(Exhibit F marked for identification.)

BY MS. FLECHSIG:

Q. This is a letter dated July 29th, 2019, and it's signed by S. Khan, M.D.; correct?

A. Yes, I've seen this before.

Q. Okay. Is that the cardiology clearance letter?

A. It is. It would be, yes.

Q. Okay. So with Mr. Snookal's cardiologist saying that "Mr. Snookal's under my care for his heart condition. It is safe for him to work in Nigeria with his heart condition. His condition is under good control and no special treatments are needed"; ultimately, someone still made the determination that Mr. Snookal was not fit for duty; correct?

A. Correct.

Q. And is it because despite Mr. Snookal's ability to complete the job, Chevron felt it was too great of a risk in the event he had to be evacuated?

MR. MUSSIG: Calls for speculation. Lacks foundation.

THE WITNESS: So the issue is -- I'll tell you

definite risk, not a theoretical risk. And then the ability to manage that risk is -- was -- was the basis of their decision. There was -- I would say there's nothing theoretical about that 2 percent.

BY MS. FLECHSIG:

Q. For example, would a pregnant woman be allowed to go to Escravos, Nigeria?

MR. MUSSIG: Calls for speculation. Lacks foundation. Incomplete hypothetical. Vague as to "go to."

THE WITNESS: Yeah, so I would say -- yeah, it's complicated. And what we need to know is how -- what term she was in, whether the expectation would be that we'd allow a delivery on the ground in Escravos for this individual. There are a lot of factors in there.

I would say certain women who are pregnant with high risk, so high-risk babies, IVF, previous complications, known complication of the current pregnancy, those things would be disqualifiers for sure.

BY MS. FLECHSIG:

Q. In terms of health conditions that are not actively impacting someone's ability to do the job, what makes it too high risk for Chevron?

MR. MUSSIG: Calls for speculation. Lacks foundation. Asked and answered.

THE WITNESS: It's not the job. It's the location. So Chevron has a duty of care for their employees. And we need to ensure that the quality of care delivered to our employees who we move around the world are consistent or compatible with what they would have received in their home country.

So I would say it's the duty-of-care question and -- and the assignment. It's the location, not the -- not the job here.

BY MS. FLECHSIG:

Q. To confirm, the location of Escravos, Nigeria, would not impact Mark's aortic aneurysm; correct?

In other words, being in Escravos, Nigeria, would not affect the risk of an adverse event for Mr. Snookal; correct?

A. Not based on --

MR. MUSSIG: Calls for speculation.

THE WITNESS: Not based on his written job desc- -- requirements. However, I would look at the aneurysm as -- with -- with the risk, it's 2 percent and likely to grow -- I'll just say it's 2 percent, and I would consider it more like a ticking -- ticking clock. And it's just -- or a ticking time bomb, and it's just a matter of time until it stops ticking.

And so -- so that's what the -- so the -- his

risk is when -- when he does have an issue with that heart -- and, again, we hope it never happens. It's -- it would be a disaster if it happened in Escravos.

BY MS. FLECHSIG:

Q. Right.

A. Because we can't provide that duty of care to him. We wouldn't have been able to get him to a high-quality tertiary care medical center that could sort this issue.

Q. Right. But what I'm asking is in terms of the likelihood of having an adverse event, it doesn't matter whether Mr. Snookal is in Los Angeles; Texas; Escravos, Nigeria; the risk of the adverse event happening remains the same; correct?

A. Correct. But the outcome would be different based on those locations. The outcome would be different based on his -- the time to get to a high-quality medical center. The -- the -- even across medical centers -- all across the U.S., those that have -- that see more cases per year have better outcomes than those that see less cases per year.

So -- so we're talking about, yes, the problem would happen, and then if he lived in certain locations, he would do better if that problem happened than if he lived in others.

CERTIFICATE OF STENOGRAPHIC REPORTER

I, RACHEL N. BARKUME, a Certified Shorthand Reporter of the State of California, hereby certify that the witness in the foregoing deposition,

SCOTT LEVY, M.D.,

was by me duly sworn to tell the truth, the whole truth, and nothing but the truth in the within-entitled cause; that said deposition was taken at the time and place therein named; that the testimony of said witness was stenographically reported by me, a disinterested person, and was thereafter transcribed into typewriting.

Pursuant to Federal Rule 30(e), transcript review was requested.

I further certify that I am not of counsel or attorney for either or any of the parties to said deposition, nor in any way interested in the outcome of the cause named in said caption.

DATED: September 12, 2024.

Rachel N. Barkume

Rachel N. Barkume, CSR No. 13657, RMR, CRR

EXHIBIT 12 -C

Subject: Patient MS

From: "Steven H. Khan" <Steven.S.Khan@kp.org>

To: "scottlevy@chevron.com" <scottlevy@chevron.com>

Cc: "mark@maygus.com" <mark@maygus.com>

Fri, 23 Aug 2019 21:35:33 +0000

Hi Dr. Levy,

I received your voicemail about Mr. MS who is a Chevron employee and my patient here at Kaiser.

I understand he is applying for a job in a rural or remote area of Nigeria and I understand the concern about his aortic aneurysm.

I just spoke to Mr. MS and received his permission to email you back. I am also copying him on this email.

Mr. MS's aneurysm is relatively small and considered low risk. His Thoracic aortic aneurysm size is 4.1-4.2 cm on his most recent CT scan.

From the published studies, the risk of rupture or dissection is 2% per year for aneurysms between 4.0 and 4.5 cm (Ann Thor Surg 2002 Vol 73, pg 17-28, figure 3).

Further, the average rate of growth of thoracic aortic aneurysms is 0.1%/year and Mr. MS's aneurysm has not changed between his CTs in May 2016, May 2017, and April 2019.

Since Mr. Snookal's aneurysm has not shown any growth for 3 years, his risk may be lower than the published 2% number above which would be based on "average" growth rates.

Finally, the studies of risk of rupture are fairly old (2002) and treatment has improved as has our understanding of aortic aneurysms.

For example, animal studies have shown a significant benefit from use of Angiotensin Receptor Blockers (ARB) in preventing or even reversing aortic aneurysm growth and Mr MS

Is on an ARB.

In summary, Mr. MS's risk of serious complications related to his thoracic aortic aneurysm is low and likely less than 2% per year.

The risk is primarily related to further enlargement of the aneurysm which can be tracked with an annual CT scan.

If you have any further questions, please feel free to email me or call me.

Best regards,

S. Khan, MD

Clinical Associate Professor, UCLA School of Medicine

Heart Failure and Transplant Cardiology, Kaiser Permanente

EXHIBIT 12 -D

Snookal, Mark

From: Levy, Scott
Sent: Monday, September 16, 2019 4:20 AM
To: Snookal, Mark
Subject: medical

Mark,

I spoke with Andrew Powers who briefed me on your recent discussion with him and let me know that you were waiting on written documentation and perhaps further explanation of your recent MSEA (medical suitability for expat assignment) examination. I'll do my best to explain in writing but also happy to further discuss live.

As you know, foreign assignments (including, Escravos Nigeria) can be in locations where access to critical prescription medications or medical care is extremely limited. For these and other reasons, we conduct an MSEA to confirm that an employee is medically able to work in the new job and location.

I understand that you are willing to take the risk of potentially dying on the job, and that you do not feel it is the company's place to make that decision for you. I agree to a certain extent and recognize your concerns about paternalism. However, the company does have a right to not engage individuals where their assignment could pose a "direct threat" to their own health and safety.

We certainly don't believe that every employee with a health condition poses a direct threat; we need to analyze the condition and the attributes of the job. When there are ways of ameliorating the risks (including reasonable accommodations) we work with the individual to do so. I became involved on your case when you had requested a second opinion on the initial denial and with your consent involved your treating physician to better understand your specific risk. While reasonable professionals can debate the exact percentage, we are dealing with an established risk that is several magnitudes higher than the baseline and is a realistic possibility. We respectfully disagree that this finding (regardless of the exact percentage) is based on stereotypes, as distinguished from objective medical evidence. But the risk itself is not determinative. The concern is that if the condition were to occur, the outcome would be catastrophic and would require an immediate emergency response which is not available and would most certainly result in death in Escravos. There is no medical capability to manage this type of emergency in Escravos or anywhere near Escravos. It is also clear that the duration of your condition is not limited and is continually present, and the occurrence is not predictable and it's not possible to isolate triggers to reduce the risk.

We have no problems with you working in El Segundo and believe there are many other foreign locations where you could work. We in fact discussed whether you could perform this particular job at a different location in Lagos, but it wasn't possible.

In response to your question, I would not foresee issues with you working in the following locations:

Americas: US onshore operations, San Ramon, Houston, Calgary, Vancouver, St. John, Argentina (Buenos Aires); Colombia (Bogota); Brazil (Rio de Janeiro), Trinidad (Port of Spain)

Asia Pacific: Singapore, Australia (Perth based), Hong Kong, New Zealand, Thailand (Bangkok, Rayong, Sirai Chi); South Korea (Seoul, Ulsan, Geoje), Philippines (Manila), China (Beijing, Shanghai), Japan Metropolitan; Malaysia (Kuala Lumpur); Pakistan Metropolitan

EEMEA: UK (all locations), Belgium (all locations), Denmark (all locations), France (all locations), Italy (all locations), Netherlands (all locations), United Arab Emirates (all locations), Norway (all locations), Germany (all locations), Sweden (all locations), South Africa (all locations), Bahrain (all locations), Qatar (all locations), Kuwait (all locations), Turkey (all locations), Poland (all locations), Saudi Arabia (all locations), Nigeria (Lagos), Russia (Moscow)

I'd need to do a more specific assessment for:

Americas: US offshore operations (Deepwater), Colombia (Riohacha); Argentina- Nuquen, Colombia –Rio Hacha, Guatemala, Panama, Mexico, Brazil Offshore, Kitimat (Canada)

AP: Australia (Barrow Island, Onslow, Dampier, Karratha, Thevenard Island & Wheatstone offshore); Bangladesh (Dhaka); China (Chengdu, Tianjin, Tanggu); Indonesia (Jakarta, Sumatra, Balikpapan); Malaysia (Lumut); Thailand (Songkla, Nakorn Srithammarat - NST, Offshore); Vietnam; India

EEMEA: Angola (Luanda); Nigeria (Lekki, Abuja), Azerbaijan (all locations), Ukraine (all locations), Romania (all locations), Rep. of Congo (Pointe Noire), Morocco (all locations), Egypt (all locations), Russia (outside Moscow).

I'd be quite concerned about other locations. As I mentioned above, I'd be more than happy to discuss this with you further.

Scott

Scott Levy
Regional Medical Manager, Europe, Eurasia, Middle East & Africa
TR & HM COE

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Important Message from the Global Privacy Team

Remember that when it comes to sharing personal data, **less is more**. Do not share more information than is being requested from you. Share information securely and follow company policy by **encrypting**emails and attachments that contain **sensitive personal data**. Before clicking "send" on an email,**double-check** that the email is addressed to the people you actually want it to go to! Do not forward emails containing detailed information about a patient's health or wellbeing when a summary would suffice. Wherever possible, anonymize personal data by removing patient names and other individual identifiers. Finally, don't hesitate to contact the Global Privacy Team if you have any questions:privacy@chevron.com

EXHIBIT 12 -E

Chevron

Medical Suitability for Expatriate Assignment History & Physical Examination

GO-146-MSEA

Mark Snookal
CAI - MVZM

07/24-15

RECEIVED
JUL 24 2015
BY

Initial
Nigeria

Note to Examinee and Examiner: In the US, the Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information for any U.S. based employees (whether within the U.S. or outside the U.S. on assignment) when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Local or Host Country legal requirements may also apply.

Part A. Examinee: Please complete Parts A through F prior to exam.

F.I.	M.I	Last Name	First Name	CAI	Gender
		Mark Snookal		MVZM	M

Current Job Title	New Job Title*	Current Company/BU/OpCo	Next * Company/BU/OpCo	Current Location	Next * Location
IEA Reliability Team Lead	Reliability Engineering Manager	ESE	NMASBU	El Segundo CA USA	Escravos, Nigeria

*If Applicable

Part B. Your country of assignment may or may not have full medical resources to support your health needs. Please answer the following questions as accurately as possible and check 'N' (no) or 'Y' (yes) in the column. Answers with Yes, please provide more information in the description boxes. This information is used to promote your safety and ensure your health needs can be met.

(If need, please use back page)		N	Y	Description
1.	Do you have any medical, physical or psychological conditions under the care of a health professional? If yes, please describe.	☐	☒	I have a dilated aortic root. I am under the care of a cardiologist and see him once per year for a checkup. I have consulted with him on this assignment and he sees no issues with it.
2.	(a) Are you taking any medicines that require a prescription? If yes, please list.	☐	☒	Losartan and Amlodipine
	(b) Are you taking any non-prescription medicines on a frequent basis? If yes, please list.	☒	☐	
3.	(a) Do you have any allergies?	☒	☐	
	(b) Have you ever had severe allergic reactions? If yes, do you know what caused it?	☒	☐	
4.	Do you exercise for at least 30 minutes 3 times a week, on average?	☐	☒	
5.	(a) Do you feel unusual fatigue or sleepiness?	☒	☐	
	(b) Do you have any problems sleeping?	☒	☐	
	(c) Do you use sleeping aids, including medication?	☒	☐	
6.	Have you ever experienced health problems working in extreme weather conditions?	☒	☐	
7.	Have you experienced unexplained weight loss or gain?	☒	☐	
8.	(a) Do you smoke? If yes, what and how much each day?	☒	☐	
	(b) Did you smoke regularly for more than 1 year ever in your past?	☒	☐	
9.	Do you drink alcoholic beverages? If yes, what is your average weekly intake?	☒	☐	
10.	Have you ever required a medical evacuation from a work location? If yes, what was the reason?	☒	☐	

EXHIBIT E
Scott Levy, M.D.
8/30/2024
Rachel N. Barkume, CSR, RMR, CRR

GO-146 - MSEA (6-18)
Word Electronic Version

SNOOKAL-00605

Examinee Last and First Name	Examinee CAI
Mark Snookal	MVZM

11.	Have you ever had any mental health or psychological issues requiring at least a medical prescription? If yes, please describe	☐	☒	I was treated for depression with Effexor for a few years from approximately 1994-1996
12.	Have you been in the emergency room and or hospitalized within the last six months?	☒	☐	
13.	Have you undergone any surgical procedure or operations within the last six months?	☒	☐	
14.	Did you have a physical (periodic, preventive) exam within the past two years?	☐	☒	
15.	Would you need health/medical resources for any disabling or special condition in the country of assignment?	☒	☐	
16.	Would you like to schedule a discussion with a Chevron Physician or Regional Medical Manager to discuss further a health condition or learn more about the host country medical resources?	☒	☐	
17.	Does your new position require you to work or travel Offshore, In Field/Plant or Strictly Office? Please advise If you need additional certifications for your new position (e.g. HUET/BOSIET, Oil and Gas U.K.)	☐	☐	My position is strictly office

Part C. Please answer the following questions and check 'N' (no) or 'Y' (yes) in the column. If 'Y' please describe.

Have you had any illness or condition related to the following body parts or systems? (minor conditions do not need to be mentioned):		N	Y	Description
18.	Head and Neck	☒	☐	
19.	Eyes or Visual	☒	☐	
20.	Ear, Nose and Throat	☒	☐	
21.	Teeth (a) When was your last exam? (b) Is there any dental work pending? Please describe	☐ ☒	☐ ☐	11/2017
22.	(a) Chest such as shortness of breath, chronic cough. (b) Breasts	☒ ☒	☐ ☐	
23.	Heart such as chest pain, palpitations or irregular beating	☐	☒	I have PVC's which have been evaluated by a cardiologist and do not require any treatment
24.	Abdomen such as pain, hernias, abnormal bowel movement	☐	☒	I had my gallbladder removed in 2014
25.	Kidney, bladder or genital area	☒	☐	
26.	Spine and Musculo-skeletal, movement limitations or pain	☒	☐	
27.	Skin changes such as rash, spots, moles or itching	☒	☐	
28.	Epileptic seizures, dizzy spells or migraine	☒	☐	
29.	Diabetes or increase in blood sugar	☒	☐	
30.	Anemia or other blood conditions	☒	☐	
31.	Tuberculosis (TB) or positive TB test, skin or blood (e.g. TB spot, IGRA/ *Quantiferon®*)	☒	☐	
32.	Any other health problems (Please use space below. If need, use back page)	☒	☐	

Examinee Last and First Name	Examinee CAI
Mark Snookal	MVZM

Part D. Exposure History (Employee Only)

Have you ever been exposed at work to dusts, solvents, other chemicals or any other known workplace hazards, e.g. biological agents?

☒ Yes ☐ No

If YES, please list agents with dates and for how long:

I have worked in industrial and petrochemical locations from 1990 present

Have you ever been exposed in the workplace to:

☒ Noise ☐ Radiation/X-ray Equipment ☐ Vibrating Hand Tools ☐ Repetitive Movement ☐ Weight Lifting ☐ Other

If you checked one of the boxes above, please specify for how long, and whether Personal Protective Equipment (PPE) was used:

In my work in industrial and petrochemical locations from 1990 present I have been exposed to noise but have always used PPE

Part E. Occupational History (Employee Only)

Have you ever been part of a medical (health) surveillance program through your work due to exposure to workplace hazards? e.g. Part of a hearing conservation program due to exposure to workplace noise.

☒ Yes ☐ No

If YES, please list with dates:

I am currently in a hearing conservation program in my employment with Chevron El Segundo

Part F. Family History

To comply with the US Genetic Information Nondiscrimination Act of 2008, this part should NOT be completed for any US based employees (whether in the U.S. or outside the U.S. on assignment). Any information inadvertently provided for a US employee in this section should be redacted if the form is to be sent to the US for filing in the employee's medical record. Local related legislation may be also applicable.

Are there any medical conditions within your family relevant to be mentioned?

Physician Comments:

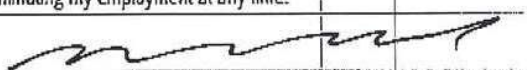
Have you ever been employed with Chevron or examined for employment by Chevron?

☐ No ☒ Yes If yes, when At hiring at Chevron El Segundo in 2009

EXAMINEE:

I certify that the information given by me is true and I authorize the examiner to furnish the results of this examination and other related medical investigation results to either the Chevron Regional Medical Managers or the Chevron Global Health and Medical facility. I acknowledge and agree that the results of this medical evaluation are managed by Chevron in a secure and confidential data system that will store and may transmit information to countries other than where the medical examination takes place, including but not limited to the U.S.

FOR APPLICANT ONLY: I understand that any misrepresentation, false statement or omission herein may result in the company rejecting my application, withdrawing any offer of employment, or terminating my employment at any time.

Examinee Signature  Date (mm/dd/yyyy) 7/18/2019

Examinee Last and First Name	Examinee CAI
Mark Snookal	MVZM

Part G. PHYSICAL EXAMINATION. To be completed by Health Care Provider.

Vital Signs

HEIGHT ft/cm	WEIGHT lb/kg	BMI	Abdominal Circumference in/cm	B.P. (mmHg)	PULSE	Temperature (°C/°F)
72"	256lbs	34.7		135/78	53	97.5

Vision

	Uncorrected			Corrected			Depth	Tonometry	Color Vision	Visual Fields
	Both	Right	Left	Both	Right	Left				
Far	20/ 6/	20/ 6/	20/ 6/	20/ 16 6/	20/ 10 6/	20/ 16 6/			Normal	
Near	J#	J#	J#	J# 1 +	J# 1 +	J# 1 +				

N	A	N = Normal. A = Abnormal, please describe	DESCRIPTION
☑	☐	1. General Appearance	
☑	☐	2. Head	
☑	☐	3. Ear, Nose Mouth and Throat	
☑	☐	4. Neck	
☑	☐	5. Eyes	
☑	☐	6. Chest	
☑	☐	7. Breasts	
☑	☐	8. Respiratory System	
☐	☐	9. Cardiovascular System	occas ectopics (PVC's)
☑	☐	10. Abdomen, Viscera/Hernias	
☑	☐	11. Genito-urinary	
☑	☐	12. Lower GI Tract	
☑	☐	13. Extremities	
☑	☐	14. Spine and Musculo-skeletal. Range of Motion.	
☑	☐	15. Skin and Lymphatic System	
☑	☐	16. Central Nervous System	
☑	☐	17. Peripheral Nervous System Reflexes	
☐	☐	18. Others, please specify	

GO-146 - MSEA (5-18)
Word Electronic Version

SNOOKAL-00608

EXHIBIT 12-E-4

Examinee Last and First Name	Examinee CAI
Mark Snookal	MVZM

LABORATORY AND SPECIAL TESTS

N	A	Not Done	AS INDICATED	RESULTS. N = Normal. A = Abnormal, please describe
☐	☐	☑	Audiogram	
☐	☐	☑	Chest X Ray	
☑	☐	☐	Complete Blood Count	
☐	☐	☑	Drug Screening	
☐	☑	☐	ECG	
☐	☐	☑	Pulmonary Function	
☑	☐	☐	Serum Profile/Chemistries	
☐	☐	☑	Stress Test	
☑	☐	☐	Urinalysis	
☐	☐	☐	Others, please specify	

REMARKS: Describe significant / abnormal findings/limitations noted above (if need, please use back page)

(1) PVC's - frequent asymptomatic followed by cardiology
(2) Dilated aortic root followed by cardiology
ongoing studies yearly Echo vs CT chest
Stable on meds

If any abnormalities were found during the examination, was examinee informed? ☑ Yes ☐ No

Part H: MEDICAL RECOMMENDATION

H.1. Fitness for Duty Classification, ONLY FOR INTERNAL CHEVRON USE

- ☐ A. Fit for Duty
- ☒ B. Fit for Duty with Restrictions
- ☐ C. Not Fit for Duty
- ☐ D. Failed to comply with requested evaluations, due to:

H.2. Restrictions pertinent to Job Requirements (refer to GO-308)

No heavy lifting >50lbs
needs review of
Recommend letter from
cardiologist to clear him

Examiner's Name (please print): IRVING SOBEL MD
Signature: [signature]
Date (mm/dd/yyyy): 07/24/2015
USA Chevron Provider Number: 111408

Address: 4676 ADMIRALTY WAY 4TH FLOOR MDR CA 90292
Street / City / State / Province / Postal / Zip Code / Country

Chevron Global Health & Medical Approval (please print name)
Signature
Date (mm/dd/yyyy)

GO-146 - MSEA (6-18)
Word Electronic Version

SNOOKAL-00609

EXHIBIT 12-E-5

Examinee Last and First Name	Examinee CAI
Mark Snookal	MVZM

PLEASE ATTACH COPIES OF IMPORTANT REPORTS OF CURRENT INTEREST.
If available, Form GO-308 (Physical Requirements and Working Conditions) must be included.

SNOOKAL-00610

EXHIBIT 13

UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

MARK SNOOKAL, an individual,

Plaintiff,

vs.

CHEVRON USA, INC., a California Corporation, and DOES 1 through 10, inclusive,

Defendants.

Case No.

2:23-cv-6302-HDV-AJR

DEPOSITION OF DR. UJOMOTI AKINTUNDE

OCTOBER 31, 2024

CONDUCTED VIA ZOOM VIDEOCONFERENCE

REPORTED BY LAUREN RAMSEYER, CSR NO. 14004

EXHIBIT 13-1

UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

MARK SNOOKAL, an individual,

Plaintiff,

vs.

CHEVRON USA, INC., a California Corporation, and DOES 1 through 10, inclusive,

Defendants.

Case No.

2:23-cv-6302-HDV-AJR

DEPOSITION OF DR. UJOMOTI AKINTUNDE,

commencing on Thursday, October 31, 2024, at 8:00 a.m., Pacific Time, held via Zoom videoconference, all participants appearing remotely before Lauren Ramseyer, Certified Shorthand Reporter, CSR No. 14004.

I N D E X

WITNESS:

DR. UJOMOTI AKINTUNDE

APPEARANCES:

FOR THE PLAINTIFF:

ALLRED, MAROKO & GOLDBERG

BY: OLIVIA FLECHSIG, ESQ.

6300 Wilshire Boulevard, Suite 1500

Los Angeles, California 90048

(323)653-6530

oflechsig@amglaw.com

FOR THE DEFENDANTS:

SHEPPARD, MULLIN, RICHTER & HAMPTON, LLP

BY: SARAH FAN, ESQ.

333 South Hope Street, 43rd Floor

Los Angeles, California 90071

(213)620-1780

sfan@sheppardmullin.com

ALSO PRESENT: EGUONO ERHUN

Q. Okay. In your practice as a cardiologist, have you ever treated an aortic aneurysm that ruptured?

A. No.

Q. In your practice as a cardiologist, have you ever treated an aortic aneurysm that dissected?

A. No.

Q. Do you have a current curriculum vitae or resume?

A. I would have to update it. I have not applied for any job since I started working at Chevron.

Q. Okay. So the most recent version would be from around 2018?

A. Approximately. There have been some updates along the line of -- definitely it's not -- it's not recent. I do not have it current.

Q. In your work as a cardiologist, have you ever treated someone with a dilated aortic root?

A. Yes.

Q. How many people do you think that you've treated with a dilated aortic root?

A. I cannot remember. I didn't do counts.

Q. I understand. What's your best estimate? Is it between five and ten, ten and 20, over a hundred? You know, what sort of would be your best estimate of the range of the number?

MS. FAN: Objection. Vague and ambiguous.

THE WITNESS: I can't remember. I'm not so sure how many, but I have managed them in the past. They're not as common in this part of the world.

BY MS. FLECHSIG:

Q. In the last year, how many patients with a dilated aortic root have you -- have you treated?

A. A couple. I'm not sure exactly.

Q. Since joining Chevron in 2018, how many people with a dilated aortic root have you -- have you seen?

MS. FAN: Vague and ambiguous as to "Chevron."

THE WITNESS: I'm not certain of the exact number, but I've seen a few.

BY MS. FLECHSIG:

Q. So I want to turn now to Mark Snookal, the plaintiff in this case. Have you ever spoken with Mr. Snookal?

A. No.

Q. Have you ever reviewed a job description for the position that Mr. Snookal was seeking in Escravos?

A. No.

Q. Did you have any work history, for Mr. Snookal, to review?

A. No. That's not within my purview as a cardiologist. That's managed by the occupational health

physician.

Q. Okay. I think I want to just go ahead and turn towards the email that I believe you were referring to earlier. I'm going to put the document in the chat so that you can scroll through it at your leisure, just give me one moment to give you the file.

(Exhibit 1 was marked for identification.)

BY MS. FLECHSIG:

Q. So I'm marking as Exhibit 1 what's been provided as CUSA000771 through 000775.

Dr. Akintunde, please go ahead and open the document, and you're welcome to take a moment to look through it. And then you can let me know when you're done.

A. I've looked through it.

Q. Okay. Is this the email that you were referring to earlier in terms of the document you reviewed to prepare for your deposition today?

A. Yes.

Q. Is this the entire email thread that you had with Dr. Asekomeh relating to Mr. Snookal?

A. Yes.

Q. Okay. Other than this email, did you discuss Mr. Snookal with Dr. Asekomeh at any other time?

A. I don't recall at all. That was five years

A. Two imaging reports.

Q. Okay.

A. The CT and the echo.

Q. Okay. So this email thread, it looks like Dr. Asekomeh sent the first email to you on, let's see -- on August 6th, 2019; is that correct, he forwarded you the thread?

A. I think it was August 7th.

Q. So I'm looking at --

A. Oh, maybe it was the 6th. I can't remember. It's possible.

Q. That's okay. I'm not trying to trick you. I'm just trying to get a good sense of the timeline in terms of what the document says.

So on the first page of the document, CUSA000771, it looks like there's an email from Dr. Asekomeh. It says sent Tuesday, August 6, 2019, 12:35 to Akintunde, and then it looks like your Chevron email. Is that -- are you seeing what I'm reading out?

A. Yes.

Q. Okay. So that was what you received from Dr. Asekomeh relating to Mr. Snookal, correct?

A. Yes, that's correct.

Q. Okay. And so when you received that email, you did not also receive the medical summary that's on

the last page of this thread?

A. No.

Q. Okay. So I understand you received just -- I think you said two imaging reports, right?

A. Yes. Yes.

Q. Apologies if I already asked this. What were the imaging reports of?

A. Echo, cardiology, and CT scan.

Q. Okay. And so I see in your response email, if you scroll up so we're still on 771, the first page of the document, in this -- this is the email response that you wrote to Dr. Asekomeh, correct?

A. Yes.

Q. Okay. So just going down the -- going down in order of what you wrote, you said, "I concur with my colleagues." That was in reference to the remainder of the email thread, right?

A. Yes.

Q. And then you say he is, quote, low risk, but not low risk, correct?

MS. FAN: Objection. Misstates the document.

THE WITNESS: Correct.

MS. FAN: Counsel, I think you might have flipped those terms.

Lagos. So I would say it was more general cardiology.

Q. For people that you were treating with hypertension, what were you doing for them?

A. Clinical exams, review of their medications, EKGs, when required.

Q. Okay. And that was on location at Escravos, correct?

A. Correct.

Q. I think you said that you didn't have all of your cardiology equipment available at Escravos. What equipment was not available while you were in Escravos?

A. There's no intensive care unit at Escravos, no echo machines. It's just a basic clinic.

Q. Okay. While you were in Escravos, did you have any medical emergencies that required emergency evacuation?

A. Yes.

Q. How many?

A. I don't think I'm allowed to give that kind of data.

Q. Well, the attorneys haven't objected. I don't -- I personally think it's fine. It's not something that is specific. So just to clarify the scope, you don't need to identify the person or anything like that. I'm just wondering how many emergency

medical evacuations took place while you were there.

A. In a week, maybe two. Maybe one or two. Sometimes less; sometimes more.

Q. So one to two per week would be your best estimate of the average emergency medical evacuations?

A. Yeah. It would just -- it should be an estimate.

Q. Do you know what would happen during those medical evacuations, like do you know how they were evacuated?

MS. FAN: Objection.

THE REPORTER: I'm sorry, what was the objection?

MS. FAN: It was vague and ambiguous.

BY MS. FLECHSIG:

Q. You can go ahead, Dr. Akintunde, or I can -- I can say the question again.

A. Can you please say the question again?

Q. Yeah. When someone needed to be medically evacuated on an emergency basis, do you know how the evacuation took place, like how were they evacuated?

A. By chopper.

Q. Okay. Is that true for all of the medical evacuations that took place while you were in Escravos?

A. Most of them.

Q. Okay. For the ones that were not evacuated by chopper, how were they evacuated?

A. So if they needed referrals, but not really those kind of emergencies, we would put them on a regular flight.

Q. Okay. When you say a "regular flight," are those -- those are, like, fixed wing airplanes that are coming and going from Escravos?

A. I'm not sure I know what fixed wing is, but regular airplanes that are coming in and out of Escravos.

Q. How often are regular airplanes coming and going from Escravos?

A. At least three times a week.

Q. Okay. For the people that needed to be emergency evacuated by chopper, do you know how quickly they were able to get onto the helicopter for evacuation?

MS. FAN: Objection. Vague and ambiguous.

I apologize, Dr. Akintunde. You can go ahead.

THE WITNESS: That varied a lot. Back then it was a company in Escravos, so sometimes evacuations were delayed. Sometimes a chopper wasn't regularly available, you had to wait for one to come back, so that varied a lot. There's no one size fits all.

MS. FLECHSIG: Yeah, absolutely. I think I just have a couple more questions on this point, and then we can do a little break.

MS. FAN: Great.

BY MS. FLECHSIG:

Q. I know you mentioned it could vary a lot in terms of the time it took to get, you know, a chopper to the site. What was the average time you think that it took to get someone on to the helicopter for evacuation?

MS. FAN: Objection. Vague and ambiguous. Calls for speculation.

THE WITNESS: How much time? Maybe an hour and a half. I think about that. That's just an approximation.

MS. FLECHSIG: Okay. All right. Do we want to take a five-minute break, a ten-minute break?

MS. FAN: I think five minutes should work.

MS. FLECHSIG: Is that okay with everyone?

THE WITNESS: That's fine.

THE REPORTER: That's fine with me.

MS. FLECHSIG: Okay. Thank you so much.

MS. FAN: Great. We can go off the record.

THE REPORTER: We're off the record.

(Recess.)

identifying details.

A. Yes, I did see a hand injury, trauma, you know, yes, a hand injury. Yeah, very few, but I did see, yes, a hand injury.

Q. What -- were there any other traumas that you treated while you were in Escravos?

MS. FAN: Objection. Vague and ambiguous.

THE WITNESS: I can't remember, but I guess -- I think -- I think somebody while playing sports on the field, I can't remember what -- we did see some mild trauma, maybe muscle, you know, twisting the muscle or something, yeah. There were some, definitely.

BY MS. FLECHSIG:

Q. Okay. During the time you were in Escravos, was anyone injured because of a medical evacuation, in other words, was anyone injured due to the process of an emergency medical evacuation?

A. No.

Q. Does a dilated aortic root pose a physical danger to anyone other than the person who has the dilated aortic root?

MS. FAN: Objection. Vague and ambiguous. Incomplete hypothetical. Calls for a legal conclusion.

THE WITNESS: No.

MS. FAN: Objection. Argumentative.

THE WITNESS: Well, size is important, so the risk is lower that it would dissect or rupture, but it may also -- that may also occur, even at the current size; that is why there is a risk category to it. So you really want to make sure, like I said, as a physician, my priority one is the health and wellbeing of every patient, so I also want to make sure all the factors that may potentially increase the risk of this person are doing well, are put into perspective and addressed.

BY MS. FLECHSIG:

Q. In your email did you intend to express any opinion about whether it was safe for Mr. Snookal to work in Escravos?

A. That's not within my sphere of work. My communication was strictly cardiology, about the signs, and its possible issues that may arise. Nothing within my sphere of work allows me to determine suitability for work or otherwise.

Q. For someone with an aortic root of 4.2 centimeters, is that a situation where you would recommend surgical intervention?

A. I would not recommend surgical intervention at that size except he didn't have symptoms.

Q. What are --

A. If he has no symptoms, then I would say no to surgery at that time.

Q. What are symptoms of a dilated aortic root?

A. Tearing chest pain, blood pressure will drop, amongst others.

Q. Okay. What are the others, if you know?

A. There are so many, like, I won't go into all of that right now, but they are listed in the email trail there, so...

Q. Okay. I think I see in -- I think I see what you're referring to in the email trail from Dr. Aiwuyo, he says, "Watch out for alarm symptoms like pain in the chest, throbbing, tearing, aching or sharp pain, often sudden; pain in the back, nausea, vomiting, fainting and systemic shock."

Is that -- are those the symptoms that you're referring to?

A. Yes.

Q. Just to clarify, those symptoms, does that indicate a dissection or rupture, or is that just what a symptomatic aortic root is?

A. It can indicate either one of them, and all of that refers to symptomatic pieces.

Q. And, honestly, I'm just asking because I'm not

review -- strike that.

I want to ask about -- I actually want to ask about the CT scan and the echocardiogram that you said were attached to Dr. Asekomeh's email. Do you know what I'm referring to?

A. Yes.

Q. The CT scan, was it just one CT scan, or were there multiple CT scans?

A. So I remember correctly it was one CT.

Q. Okay. For the echocardiogram, was that attachment -- or were there attachments that were multiple echocardiogram or just one echocardiogram?

A. I recall one echocardiogram.

Q. Okay. So based off of the information that you had available to you, did you consider whether Mr. Snookal's aortic root dilation was stable in size?

A. I cannot make a determination about if it was stable in size from only one imaging report. I would have to see a series, a sequence, a series of them to determine the rate of increase over the years.

Q. Okay. So in other words, no one provided you with any information about any changes in size?

A. I was given only one set of imaging reports.

Q. Okay. In this email thread at the bottom of page 774, so CUSA000774, I want to -- I want to give you

The engineers who work there can probably give more information about that.

Q. In Exhibit 1, there is a link from Dr. Aiwuyo on the second page of the document, so it's CUSA000772. Do you see what I'm referring to?

A. I'm going there. Yes, I see the link.

Q. Did you -- did you review the contents of the link?

A. I cannot remember.

Q. Is there -- your conclusion was that Mr. Snookal, given the size of his aortic root dilation, would be considered low risk, right?

A. Yes.

Q. Do you know at what -- is there a certain size where someone becomes high risk?

A. So those risk measurements are based on a population level. So higher risk is determined by the level, the size at which you're referred for surgery. And referring for surgery is what determines high risk, so that's where the division comes in, except the person has smaller sizes and has become symptomatic, then that changes their risk categories. So it's -- it's -- those are the variables. It's not one definition. Most of the time higher risk refers to the size.

Q. At what size does someone become high risk, if

REPORTER'S CERTIFICATE

I, Lauren Ramseyer, Certified Shorthand Reporter licensed in the State of California, License No. 14004, hereby certify that the deponent was by me first duly sworn and the foregoing testimony was reported by me and was thereafter transcribed with Computer-Aided Transcription; that the foregoing is a full, complete, and true record of said proceedings.

I further certify that I am not of counsel or attorney for either or any of the parties in the foregoing proceeding and caption named or in any way interested in the outcome of the cause in said caption.

The dismantling, unsealing, or unbinding of the original transcript will render the reporter's certificate null and void.

In witness whereof, I have hereunto set my hand this day: November 19, 2024.

Lauren Ramseyer, CSR No. 14004

EXHIBIT 13-19

EXHIBIT 14

UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

---o0o---

MARK SNOOKAL, an individual, Plaintiff, vs. CHEVRON USA, INC., a California Corporation, and DOES 1 through 10, inclusive, Defendants.	Case No. 2:23-cv-6302-HDV-AJR

DEPOSITION OF

DR. VICTOR ADEYEYE

Volume 1, Pages 1 - 34

Taken Remotely Via Videoconference

Friday, November 15, 2024

Stenographically reported by:
Renee M. Bencich, CSR No. 11946, RPR

STENO
concierge@steno.com
888.707.8366
Job Number 117195

EXHIBIT 14-1

APPEARANCES

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oflechsig@amglaw.com

For Defendant Chevron USA, Inc.:

SHEPPARD MULLIN
By: SARAH FAN, Attorney at Law
333 South Hope Street, 43rd Floor
Los Angeles, California 90071
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Also Present:

Dolores Y. Leal, Attorney at Law
Allred, Maroko & Goldberg

Paris Stephen, Attorney at Law
Allred, Maroko & Goldberg

Eguono Erhun, Attorney at Law
Chevron Nigeria Limited

INDEX OF EXAMINATION

---o0o---

QUESTIONS INSTRUCTED NOT TO ANSWER

(None.)

QUESTIONS MARKED

(None.)

CONFIDENTIAL PORTIONS

(None.)

---o0o---

INDEX OF EXHIBITS

Plaintiff's Exhibits:

Exhibit No.	Description	Page
	(No exhibits marked.)	

Defendant's Exhibits:

Exhibit No.	Description	Page
	(No exhibits marked.)	

---o0o---

College of Surgeon, ATLS, Advanced Trauma Life Supports.

I also have American College of Physician, Advanced Cardiovascular Life Supports.

Also, Basic Life Supports for America.

Then, luckily, too, I have Health Management Certification of Nigerian Postgraduate Medical College, and a Physician of Emergency Medicine, Nigeria, where I also have a certification.

Thank you.

Q. Have you ever treated any patients with a thoracic aortic aneurysm?

A. In the course of my treating, I've had one case of such.

Q. Okay. When was that?

A. That was between 2010 to 2012.

Q. Okay. Do you know whether that patient had a descending aortic aneurysm or an ascending aortic aneurysm?

A. Aortic roots aneurysm. That was the patient's type.

Q. Okay. Is -- since I'm a layperson, is that -- does that mean it's an ascending or --

A. Yes --

Q. -- descending?

A. -- yes, yes. Ascending. Ascending.

a follow-up patient. Nothing could be done. Ruptured, and that was the --)

THE COURT REPORTER: There was more.

THE WITNESS: Mortality. Death. Death.

THE COURT REPORTER: Thank you.

BY MS. FLECHSIG:

Q. So was the patient alive when they first came to you?

A. Yes.

Q. Understood.

Were you able to administer any treatments to the patient before they passed away?

A. The treatment could not be given. Not available.

Q. Understood.

Do you have a current curriculum vitae or a resume?

A. Have but not updated.

Q. Okay. Do you know when you would have last updated it?

A. Over a year ago.

Q. Have you published any medical research during the last 10 years?

A. Two contributions to textbooks of medicine with over 20 publications in local and international

figure to that. Not only consultation, even medevac cases that require expats' management as a supporting facility to offshore -- location. Thank you.

THE COURT REPORTER: To offshore? Doctor, to offshore what location?

THE WITNESS: Offshore location. Offshore. Offshore. Escravos. Offshore Escravos. Escravos. Escravos. Escravos location. Offshore Escravos location.

Thank you.

BY MS. FLECHSIG:

Q. Okay. You have never spoken to Mark Snookal, the plaintiff in this case, correct?

A. Never spoken with him.

Q. Okay. Have you ever reviewed Mr. Snookal's employment history?

A. Employment history?

Q. Yes.

A. Or medical history?

Q. No, have you ever reviewed his employment history?

A. Oh, that's not within my scope.

Q. Okay. So, no, you have not reviewed his employment history, correct?

A. Yes.

MS. FAN: Asked and answered.

BY MS. FLECHSIG:

Q. That's a -- you said yes?

A. I've never reviewed his employment history.

Q. Thank you.

You mentioned also giving treatment in response to medical evacuations.

A. Yes.

Q. Do you -- do you treat people who have been medevaced from Escravos, Nigeria?

A. Yes.

Q. How often do you treat people who have been medevaced on an emergency basis from Escravos, Nigeria?

A. Putting specific number is difficult because not all cases are medevaced. Many cases are, based on --

THE COURT REPORTER: Based --

THE WITNESS: Expats advised. Based on expat advised.

BY MS. FLECHSIG:

Q. Okay. Can you give me your best estimate of how often on average you treat someone who has been evacuated from Escravos on an emergency basis? Just approximately.

A. That varies. In a year -- it's -- it's quite

UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

---o0o---

MARK SNOOKAL, an individual, Plaintiff, vs. CHEVRON USA, INC., a California Corporation, and DOES 1 through 10, inclusive, Defendants.

Case No. 2:23-cv-6302-HDV-AJR

REPORTER'S CERTIFICATION
ORAL DEPOSITION OF
DR. VICTOR ADEYEYE
Volume 1, Pages 1 - 34
Friday, November 15, 2024

I, RENÉE M. BENCICH, Certified Shorthand Reporter in and for the State of California, hereby certify to the following:

That the witness, DR. VICTOR ADEYEYE, was duly sworn by the officer and that the transcript of the oral deposition is a true record of the testimony given by the witness;

I further certify that pursuant to FRCP Rule 30(e)(1) that the signature of the deponent:

(XX) was requested by the deponent or a party before the completion of the deposition and returned within 30 days from date of receipt of the transcript. If returned, the attached Changes and Signature Page contains any changes and the reasons therefor;

( ) was not requested by the deponent or a party before the completion of the deposition.

I further certify that I am neither attorney nor counsel for, related to, nor employed by any of the parties to the action in which this testimony was taken.

Further, I am not a relative or employee of any attorney of record in this cause, nor do I have a financial interest in the action.

Subscribed and sworn to on this the 1st day of December, 2024.

Renée M. Bencich

RENÉE M. BENCICH, CSR, RPR
California License No. 11946

EXHIBIT 14-9

EXHIBIT 15

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA - WESTERN DIVISION

MARK SNOOKAL, an individual, Plaintiff, vs. CHEVRON USA, INC., a California Corporation and DOES 1 through 10, inclusive, Defendants.	)	CASE No. 2:23-cv-6302 HDV-AJR

Videotaped Remote Deposition via Zoom videoconference of SHAHID HAMEED KHAN, M.D., taken on behalf of Defendant Chevron USA, Inc., at Culver City, California, commencing at 2:06 p.m., Monday, February 10, 2025, before Marivon H. Christine, CSR No. 3735.

APPEARANCES OF COUNSEL:

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(213) 620-1780
tkennedy@sheppardmullin.com

ALSO PRESENT:

Blake Jones, Videographer

I N D E X

EXHIBITS FOR IDENTIFICATION:

risk than average. Does that make sense?

Q Yes. Thank you, Dr. Khan.

Quick question. You write that "has not shown any growth for three years." Is there a reason you selected three years as opposed to four or five or even one year? 02:32

A That's just based on the years of CT scans, which are between 2016 and 2019, so I just subtracted those and came up with three.

Q In the second or third to last line of the e-mail you write, "In summary, Mr. MS's risk of serious complications related to his thoracic aortic aneurysm is low and likely less than 2 percent per year." 02:33

In layman's terms, what does that mean?

A Well, again, he's demonstrated that the aneurysm is not growing over a three-year period, and so his risk of it starting to expand suddenly seems very low and less than average because he's demonstrated a less-than-average rate of growth over the last three years we've done CTs on him. 02:33

Q In your experience if someone like Mr. Snookal had -- I guess, not had much growth or no growth at all in his thoracic aortic aneurysm, again, from a medical perspective does that ever change over time?

A Yes, it certainly can. So he would need once a 02:34

year to come back and have a CT scan done, a CAT scan of his aorta. So we would continue to follow with an annual CAT scan.

Q And why is it that individuals like Mr. Snookal, why do they need an annual CAT scan? 02:34

A Again, just to check to see if it's getting any bigger.

Q What are some of the causes that could cause an aortic -- strike that.

What are some of the causes that would increase a 02:34 thoracic aortic aneurysm? What causes it to grow, so to speak?

A Well, one of the factors would be high blood pressure. If his blood pressure was significantly elevated, then that would be a concern. You want to make 02:35 sure his blood pressure is well-controlled.

Q Any other causes that you can think of?

A I think that would be the main one, yeah.

Q All right. Thank you.

Dr. Khan, do you have any recollection as to when 02:35 the last time you had any interaction was with Mr. Snookal?

A I do not, no.

MS. KENNEDY: I think I'm just about done. Let me see if I can track down the other document. Let's go 02:35

Q During the 35 years of general cardiology practice, as well as the transplant cardiology that you also spent time on, how many people with dilated aortic root did you treat?

A I don't know. But the early part of my career at Cedars, I think for seven-ish years, maybe, I worked in the cardiac surgery intensive care unit, so we had a fair number of people with aortic aneurysms, you know, before and after surgery. We took care of them there. 02:51

Q Let me ask it in a more answerable way. 02:52

Do you know on average how many people you saw per year with a dilated aortic root, if you just had to give me your best estimate?

A I mean, I would just be making a random wild guess. I don't know. 02:52

Q Do you know if it was less than 10 per year on average, more than 10 per year on average?

A I would guess it was probably 15 -- between 10 and 20, but again, kind of a random guess there.

Q Okay. The patients with dilated aortic root you saw; correct? 02:52

A Yeah. Yeah.

Q I want to follow up on some of the questions that Ms. Kennedy was asking. So you said that one of the reasons why a thoracic aortic aneurysm would increase in 02:53

size is high blood pressure; right?

A Yeah. I mean, if it was uncontrolled. So that's why I said you'd have to follow it closely to make sure it was controlled recently.

Q How do you control blood pressure? How does that work? 02:53

A Yeah. Primarily through medicines, some lifestyle things, low-salt diet, you know. Primarily through medicines.

Q Okay. Any other lifestyle things other than low-salt diet? 02:54

A Well, they shouldn't do strenuous isometric exertion, like, lifting weights. That could be contraindicated to lift heavy weights. You know, general cardio kind of exercise is okay to keep -- walking on a treadmill, as I recall. So cardio exercise in general is okay, but isometric kind of exercise generally is frowned on, especially very heavy lifting. 02:54

Q How heavy is heavy usually, just so I have a sense of, you know, sort of what that means? 02:54

A I mean, I don't think there is a number that we think about. I think it's something that would be a strenuous amount to lift, and that's going to be different for different people. You know, for some people that might be 30 pounds. For some it might be 50 pounds. But 02:55

it depends on the person.

Q Okay. Understood. And in terms of medication used to control high blood pressure, would Mr. Snookal be on one or more of those medications?

A Yes. He was on two: amlodipine and losartan. 02:55

Q Understood. So no other medications would have been needed to control Mr. Snookal's blood pressure?

A His blood pressure looked okay there from what I saw, but, yeah, he's apparently doing well. There were, I think, two medicines that were blacked out so I don't know, but from what I saw there were two medicines he was on for blood pressure. 02:55

Q Okay. For a patient such as Mr. Snookal where the recommendation is to get a CT, an echocardiogram once per year, why is it that he only needs to have the testing done once per year and not more frequently? 02:56

A It depends on the size of the aneurysm and the rate of growth that you're seeing. So his had been stable over the three years that we had checked him.

So once a year was adequate for him, and that's something he could have done anywhere. And it would be ideal for him to come back to the United States and have it done at the same place, but he could have it done anywhere. 02:56

Q Okay. I want to quickly direct you back to 02:57

that's the question.

Q Yeah. I guess, does it make you think that you at least must have known that it was in a rural or remote area of Nigeria?

MS. KENNEDY: I'll object to the form of the question. 02:59

THE WITNESS: I mean, it does look like I understood that this was a rural or remote location.

BY MS. FLECHSIG:

Q Okay. I wanted to ask, I guess to follow up on that, why was it in your opinion that he could perform a job in a rural or remote area of Nigeria? 02:59

A Well, a couple of things. One is that his aneurysm appeared stable. Second, his blood pressure appeared under reasonably good control; and third, the follow-up for this kind of disease is very intermittent, very periodic. 03:00

Once a year come back and have a CT scan done. It's not an elaborate follow-up, and it's not complex or difficult to follow. I mean, it's a very quick, simple visit. You just have him come in. Check the results of the CT, check the blood pressure, chat a little bit, and it's not a complicated disease process. 03:01

If it was to get bigger, then the follow-up would be more intense, but at the level he's at it's not 03:01

particularly intense. It's a straightforward type of follow-up.

Q Yeah. In terms of detecting whether the size has changed, that's the purpose of the CT, the annual CT scan?

A Yeah. 03:01

Q I wanted to ask you -- you and Ms. Kennedy discussed a little bit a citation that I've highlighted on the screen here. I think it's Annals of Thoracic Surgery, 2002, and there's a volume and page number.

A Um-hum. 03:02

Q You said you recall actually looking that study up in order to, you know, draft this e-mail; is that correct?

A Yeah.

Q Okay. What did you do to locate that study? 03:02

A Typically what I do is do a search on MedMine or PubMed, which is kind of a federal database for searching for medical questions. And then you get a list of papers that are relevant, and then I look through them and find a table that listed thoracic aneurysm size and the risks 03:02 based on that.

It could also come from the guidelines because -- I'm not actually sure if there were guidelines at this point for aortic aneurysm management, but I know there currently are guidelines for follow-up, but this is a 03:03

while ago, yeah.

Q Okay. Just to sort of put a point on this, you put in this highlighted line here, "In summary, Mr. MS's risk of serious complications related to his thoracic aortic aneurysm is low and likely less than 2 percent per year." 03:03

Why did you conclude less than 2 percent or the risk of serious complication was likely less than 2 percent per year?

A Yeah. Basically, what I mentioned before, that we had been following the aneurysm over the last three years, and the aneurysm had not grown or enlarged at all. The average person, as I mentioned, would grow about 0.1 centimeters per year, but the fact that his had not grown meant or implied that the risk of enlarging in any given year was lower than that 0.1 percent, so the risk of a problem with the aneurysm would likely be less than that reported in literature. 03:04

Q Okay. Okay. Thank you for going through that.

So do you have any recollection speaking in realtime with anyone from Chevron about Mr. Snookal? 03:04

A No, I don't. I don't remember if I spoke to someone.

Q Okay. Do you remember whether you would have been willing to speak to someone had you connected in 03:05

realtime over the phone or the internet?
A Yes, sure.
Q Would you have been willing to provide additional follow-up information had they asked for it after this e-mail? 03:05
A Yeah. Certainly.
MS. FLECHSIG: I'm going to go through an additional exhibit. I'm going to mark as Exhibit 4 what's been produced as Snookal 00779 through Snookal 00788.
(The document referenced was marked as Exhibit 4 for identification and is attached hereto.) 03:07
MS. KENNEDY: You said 779 through 788?
MS. FLECHSIG: 788, yeah, I think that's right.
MS. KENNEDY: I'm sorry. 799 through 788? 03:07
MS. FLECHSIG: Excuse me, 779.
MS. KENNEDY: Okay.
MS. FLECHSIG: 779, apologies, through -- yeah, actually, okay. Hold on. I think I found the better redacted version. Let's start with 779 through -- 03:07
MS. KENNEDY: That's dated April 9, 2019.
BY MS. FLECHSIG:
Q I think that's the same, but with fewer redactions. I apologize, but I want to show you this, as well, Dr. Khan. 03:08

Snookal 01284.

(The document referenced was marked as Exhibit 6 for identification and is attached hereto.)

BY MS. FLECHSIG:

Q And it's just one-page, Dr. Khan. I'm going to give you a second to read through it.

A Um-hum. Yes.

Q Have you seen this document before?

A I'm sure I did. I mean, I responded to it. 03:20

Q It looks like these are messages that you exchanged with Mr. Snookal via the Kaiser Permanente communication platform; is that correct?

A Right. I mean, Kaiser patients can e-mail their doctor directly and we can respond back directly. 03:20

Q Okay. So in this e-mail that Mark Snookal sent you 7-24-2019, does this look like a true and correct copy that you received?

A Yeah.

Q Okay. In it you'll see he says, "I was a successful candidate for a position working in Nigeria on a 28-day rotational assignment (28 days on in Nigeria and 28 days off in the US)." 03:21

With this rotational assignment where he's working 28 days in Nigeria and 28 days off in the United 03:21

States, the fact that he's working 28 days on at a time, would that impact your analysis of Mr. Snookal's ability to complete the job duties for 28 days at a time?

MS. KENNEDY: Objection. Lacks foundation as phrased, but you can respond, Dr. Khan. 03:22

THE WITNESS: I don't think that would be contraindicated based on his medical condition.

BY MS. FLECHSIG:

Q And why not?

A I mean, he basically just needs to get a CT once 03:22 a year and then have his blood pressure checked, but I mean, his blood pressure is under control. And most people with high blood pressure, you know, they're checked a couple times a year, but, you know, this is well within acceptable parameters for checking somebody's aortic 03:22 aneurysm and blood pressure when he's back here roughly once a month.

Q Can people also check their blood pressure themselves at home?

A Yeah, absolutely. Yeah, we encourage that now. 03:22 That's -- we encourage people to get home blood pressure cuffs, and Kaiser hands them out or sells them to patients for the patients to do that too.

MS. FLECHSIG: Okay. I think that's all I have for you, Dr. Khan. I think that's it. Thank you so much 03:23

CERTIFICATE

OF

CERTIFIED SHORTHAND REPORTER

The undersigned Certified Shorthand Reporter of the State of California does hereby certify:

That the foregoing proceeding was taken remotely before me at the time and place therein set forth, at which time the witness was duly sworn by me;

That the testimony of the witness and all objections made at the time of the examination were recorded stenographically by me and were thereafter transcribed, said transcript being a true and correct copy of my shorthand notes thereof;

I hereby certify that I am not interested in the event of the action.

IN WITNESS WHEREOF, I have subscribed my name this date: February 17, 2025.

MARIVON H. CHRISTINE, CSR
Certificate No. 3735

Marivon H. Christine, Certified Shorthand Reporter, CSR No. 3735, hereby certify:

The foregoing is a true and correct copy of the original transcript of the proceedings taken by me as thereon stated.

Dated: February 24, 2025

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EXHIBIT 15-16